CLAIMS CLUES

Publication of the AHCCCS Claims Department

MARCH 2009

AHCCCS Provider Meetings

AHCCCS Claims staff will conduct Provider Meetings for the Fee For Service Providers. It is a great forum to get together and discuss topics of concern for providers and receive updates on AHCCCS Fee for Service Claims. We are also planning a meeting for the Yuma Area – watch for announcement in future Claims Clues.

AHCCCS Fee for Service Provider Meeting (Flagstaff Area)
Tuesday, March 17th, 2009
Flagstaff Public Library – 300 West Aspen – Flagstaff
Community Room
10:00 AM – 12: NOON
***Limited seating – please email or RSVP to**
Kyra.westlake@azahcccs.gov

AHCCCS Fee for Service Provider Meeting (Phoenix Area)
Friday, March 20th, 2009
701 East Jefferson – Phoenix
GOLD ROOM
10:00 AM – 12:00 NOON

AHCCCS Fee for Service Provider Meeting (Tucson Area)
Friday, April 10th, 2009
Northwest Medical Center
Administrative Services Office Boulding
6180 North Corona Road Suite 104
Tucson, AZ
10:00 AM - 12:00 NOON

Should you have questions regarding these scheduled meetings, please email Kyra.westlake@azahcccs.gov

AHCCCS 2/1/2009 FEE FOR SERVICE RATE REDUCTION REMINDER

As previously communicated…….
Effective February 1, 2009 the FFS Program is reducing the FFS rates by 5% for providers, with some exceptions as outlined in the public notice posted on the AHCCCS website. These rate reductions exclude plan (MCO) payments and are limited to AHCCCS Fee for Service claim payments only, with the exception of CMPD. As a result two new rate tables have been established and posted to the AHCCCS website.

CPT 99070

Effective 4/1/2009, CPT 99070 (Supplies and material provided by physician over and above those usually included with the office visit or other service rendered (list drugs, trays, supplies, or materials provided)) will no longer be an AHCCCS covered code.. Providers must use the more specific HCPCS A codes rather than 99070.

CPT 90882

Effective 3/1/2009, CPT code 90882 (Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions) will no longer be an AHCCCS covered code.

CPT 15788, 15789, 15792, and 15793

Effective 3/1/2009, the CPT codes 15788 (Chemical peel, facial; epidermal), 15789 (dermal), 15792 (Chemical peel, non-facial; epidermal) and 15793 (dermal) are available(billable) for treatment of AK lesions not amenable to individual treatment by standard methods. i.e., liquid nitrogen or surgical removal. NOTE: A Prior Authorization for these procedures is REQUIRED along with supporting medical documentation of AK lesions. Chemical peel would not be covered for treatment of acne scarring, fine lines, wrinkles, tattoos, etc.

Place of service POS changes/additions

Effective 1/1/2009, CPT code 99306 (Echocardiography, Transthoracic, Real-Time With Image Documentation (2d), includes M-Mode Recording, when performed. Complete, with spectral Doppler Echocardiography, and with Color Flow Doppler Echocardiography) can now be billed with POS 21 (Inpatient Hospital)

The CPT code 32422 (Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure) can no longer be billed with POS 24 (Ambulatory Surgical Center).

Modifier(s) – HF and/or SE

Effective for dates of service on or after January 1, 2009 the modifier(s) HF (Substance Abuse Program) and/or SE (State/Federally-Funded) have been added to the following codes.

Codes	Descriptions		
		HF	SE
H0001	Alcohol And/Or Drug Assessment	X	
H0002	Behavioral Health Screening To Determine Eligibility For Admission To Treatment Program	X	
H0004	Behavioral Health Counseling And Therapy, Per 15 Minutes	X	X
H0010	Alcohol And/Or Drug Services; Sub-Acute Detoxification (Residential Addiction Program Inpatient)	X	
H0018	Behavioral Health; Short-Term Residential (Non-Hospital Residential Treatment Program), Without Room And Board, Per Diem	X	
H0019	Behavioral Health; Long-Term Residential (Non-Medical, Non-Acute Care In A Residential Treatment Program Where Stay Is Typically Longer Than 30 Days), Without Room And Board, Per Diem	X	
H0020	Alcohol And/Or Drug Services; Methadone Administration And/Or Service (Provision Of The Drug By A Licensed Program)	X	
H0025	Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect Knowledge, Attitude And/Or Behavior)	X	X
H0031	Mental Health Assessment, By Non-Physician	X	
H0034	Medication Training And Support, Per 15 Minutes	X	X
H0036	Community Psychiatric Supportive Treatment, Face-To-Face, Per 15 Minutes	X	
H0038	Self-Help/Peer Services, Per 15 Minutes	X	X
H0043	Supported Housing, Per Diem	X	X
H0046	Mental Health Services, Not Otherwise Specified	X	

H2011	Crisis Intervention Service, Per 15 Minutes		**X**
H2012	BEHAVIORAL HEALTH DAY TREATMENT, PER Hour	**X**	
H2014	Skills Training And Development, Per 15 Minutes	**X**	**X**
H2016	Comprehensive Community Support Services, Per Diem	**X**	**X**
H2017	Psychosocial Rehabilitation Services, Per 15 Minutes	**X**	**X**
H2019	Therapeutic Behavioral Services, Per 15 Minutes	**X**	
H2020	Therapeutic Behavioral Services, Per Diem	**X**	
H2025	Ongoing Support To Maintain Employment, Per 15 Minutes	**X**	**X**
H2026	Ongoing Support To Maintain Employment, Per Diem	**X**	**X**
H2027	Psychoeducational Service, Per 15 Minutes	**X**	**X**
S5110	Home Care Training, Family; Per 15 Minutes	**X**	**X**
S5150	Unskilled Respite Care, Not Hospice; Per 15 Minutes	**X**	**X**
S5151	Unskilled Respite Care, Not Hospice; Per Diem	**X**	**X**
S9484	Crisis Intervention Mental Health Services, Per Hour		**X**
S9485	Crisis Intervention Mental Health Services, Per Diem		**X**
T1002	RN Services, Up To 15 Minutes	**X**	
T1003	LPN/LVN Services, Up To 15 Minutes	**X**	
T1016	Case Management, Each 15 Minutes	**X**	**X**
T1019	Personal Care Services, Per 15 Minutes, Not For An Inpatient Or Resident Of A Hospital, Nursing Facility, ICF/MR Or IMD, Part Of The Individualized Plan Of Treatment (Code May Not Be Used To Identify Services Provided By Home Health Aide Or Certified Nurse Assistant)	**X**	**X**
T1020	Personal Care Services, Per Diem, Not For An Inpatient Or Resident Of A Hospital, Nursing Facility, ICF/MR Or IMD, Part Of The Individualized Plan Of Treatment (Code May Not Be Used To Identify Services Provided By Home Health Aide Or Certified Nurse Assistant)	**X**	**X**

Modifiers – RA/RB

Effective for Dates of Service on or after January 1, 2009, the following two modifiers have been added for AHCCCS provider use.

RA – Replacement of a DME item
RB – Replacement of a part of DME furnished as part of a repair.

Suppliers should use the new RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen, or irreparably damaged.

In contrast, the new RB modifier should be used on a DMEPOS claim to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

HOSPITAL

Effective for Dates of Service on or after December 1, 2008, Scottsdale Healthcare – Shea has been awarded NICUIII certification. For questions, please contact Jean Ellen Schulik at JeanEllen.Schulik@azahcccs.gov.

CODING TIPS

The following are coding tips from the American Medical Association.

Diagnostic or treatment procedures that are reported as part of an evaluation and management service (e.g., otoscopy, anterior rhinoscopy, tuning fork tests, and removal of nonimpacted cerumen) are not reported separately.

Regarding the use of modifer 59 with microbiology codes: modifer 59 should be used when separate results are reported for different species or strains that are described by the same CPT code.

Behavioral Health Claims Grievances/Disputes

Arizona Department of Health Services (ADHS) (or the RBHA) is responsible for all Claims Disputes. Therefore, providers must submit any BH Claim Disputes to ADHS (or the designated RBHA) within the statutory/regulatory timeframes. If the provider has a contract which specifies differently, then the time periods in the contract must be followed.

Tribal Behavioral Health appeals should be sent to:

ADHS/DBHS
Grievance and Appeals
150 North 18th Avenue Suite 230
Phoenix, AZ 85007

For additional information refer to:
http://www.azdhs.gov/bhs/provider/index.htm

CHECK THIS OUT

New Medicaid Programs in ACE

Effective February 10, 2009, KidsCare staff will be able to determine eligibility for Medicaid programs formerly determined only by DES. Since it is estimated that about 38% of our current KidsCare households contain a member who is potentially Medicaid eligible, this will change how KidsCare processes cases and coordinates with DES.

So, rather than just screening for Medicaid and referring people to DES for a determination, KidsCare staff will be able to process the whole family at once for benefits, even if some applicants are eligible for KidsCare and others in the family qualify for Medicaid. KidsCare staff will also be able to complete renewals and changes for all of these members.

Some of the benefits to our customers are:
Reduces the time it takes for families to get a decision,
Only have to deal with one agency,
Less confusion about whether they qualify, or what information is needed,
Fewer chances of a gap in coverage due to the referral process.

Some of the benefits to the agency:
Improves our communication with the member,
Increases efficiency and reduces the time spent monitoring and working DES referrals and
Increase retention in the programs, which reduces workload.

The following Medicaid programs have been added to the ACE system: 1931 (Families with Children), SOBRA Child and Pregnant Woman, AHCCCS Care, Transitional Medical Assistance, and Continued Coverage. To support these new programs, the policy for these programs and the KidsCare program are being added to the Eligibility Policy Manual.

Changes have also been made to PMMIS as well. In Recipient, the eligibility key codes for the above programs will be the same. However, if the eligibility was determined by KidsCare staff, the source will now be “AK”.

UPCOMING CHANGES TO THE AHCCCS 835 ELECTRONIC REMITTANCE ADVICE

Effective 3/18, 2009, AHCCCS will be implementing several changes to the Electronic Remittance Advice (835).

1. File naming convention change – The 835 file name will change.
Current file naming convention will be AZD835-01-YYYMMDD-HHMMSS-XXXXXX-L.TXT.
The new file naming convention will be AZD835-XXXXXX-XX-YYMMDD-HHMMS.TXT.

- AZD835-AZ is the state, D is daily, 835 is the transaction number
- XXXXXX represents the AHCCCS provider ID number
- XX is the location code
- YYMMDD is the payment date
- HHMMSS is the process time
- TXT is the file extension

2. GS03 value – Due to internal processing purposes, the GS03 value will be 8 bytes instead of 6 bytes. The new value will be AZ and then the AHCCCS 6 digit provider ID. The new format is:

AZ- State Identification
XXXXXX-AHCCCS 6 digit provider number

3. Default values when claim is missing HCPC or Revenue Code – default values will be used when a claim is missing HCPC or Revenue Codes, as per HIR 599 and 366.

4. Claim status code – AHCCCS will now indicate if a claim is processed as secondary or tertiary.

5. Default date value when claim is missing service begin and end dates – Default value for missing service begin and end dates will be 19000101, as per HIR 601.

6. Corrected Patient/Insured Name – Patient name NM1 segment will reflect the name submitted on the claim and the Corrected Patient/Insured Name NM1 segment will contain the patient name as know to AHCCCS.

UPCOMING CHANGES TO THE AHCCCS 835 ELECTRONIC REMITTANCE ADVICE cont.

7. Claim payment amount – AHCCCS has corrected the CLP04 amount to be calculated in the following manner:

Submitted charges (CLP03) minus the adjustments (sum of CAS) equals amount paid for this claim

When reversing a claim that was paid previous to March 19., 2009, the CPL04 in the reversal claim may not be the same amount as it was reported in the original 835. We apologize for any convenience this may cause, however, this change is necessary in order to correct the issue in future transactions.

8. Claim supplemental information – interest and prompt pay discounts will be reflected in the AMT segment for all applicable claims.

9. Service payment information – The SVC segment has been corrected to properly reflect the qualifiers, codes and quantities used in the adjudication process.

10. Provider level adjustments – Interest and prompt pay discounts will be reflected in the PLB segment with the appropriate adjustment reason code on PBL03-1. In addition , the PBL03-2 will include the AHCCCS Invoice number.

Should you have any questions regarding these changes, please initiate a Customer Support ticket by sending your questions via email to EDICustomerSupport@azahcccs.gov. In addition, please periodically check the AHCCCS website for upcoming EDI changes.

CLAIM SUBMISSION EFFICIENCY TIPS

- #1 CHOICE - Submit claims electronically or,
- #2 CHOICE - Submit claims using the AHCCCS Web Portal Azweb.statemedicaid.us/Home.asp
  Refer to AHCCCS On-Line Claim Submission Manual located on the AHCCCS website (www.azahcccs.gov) for step by step instructions on how to use this tool.

NOTE : Either of the above processes ensures your claims are adjudicated in a timely manner.

- #3 CHOICE (and last resort, if the other 2 options are not available to you) AHCCCS will still accept hard copy submission of claims. These can be sent to us by USPS.

CLAIMS CORRECTION REQUESTS EFFICIENCY TIPS

AHCCCS has a form for Claims Correction Requests (CCR form). We have made a few minor changes to this form which will allow us to be more efficient in our handling of the requests that we receive. A copy of the updated form is attached for your use effective immediately.

- Any and all requests for a correction to a claim must be submitted to AHCCCS using this form. **Please do NOT send copies of your remits with notes to the side, etc. AHCCCS will return to provider with no action taken.**
- All CCRs must be signed by the Provider Representative requesting the Claims Correction. NEW – contact information for the Provider Representative requesting the Claims Correction MUST BE INCLUDED. The reason for this is – we are receiving many requests that are not clearly defined resulting in no action by AHCCCS. We would like to be able to respond back to/communicate with the Provider Representative requesting the corrections should we have questions, as we often times do.
- Be specific in the “Fields to be changed/Comments/Questions” field of the form. If we are not clear on what the Provider representative is asking us to do with the claim – no action will be taken.

CLAIMS CORRECTION REQUESTS EFFICIENCY TIPS cont.

- Be sure that the CRN included on the form is a VALID CRN – if the CRN is not valid – we can take no action on the request.
- When requesting a claim correction using the Claim Correction Request form – there is NO NEED to attach the claim. If you want to RESUBMIT the claim, that is a separate procedure all together. **Claims Correction Request Forms are just for requesting changes to claims we have already received and adjudicated.**

Claims Correction Request Forms can be faxed to 602-253-5472. Using this fax # allows the requests to be routed directly to the Imager.

MEDICAL RECORD SUBMISSION EFFICIENCY TIPS

- All Medical Records submitted to AHCCCS AFTER submission of a claim must include the MEDICAL RECORDS COVER SHEET (attached for your reference). This cover sheet allows AHCCCS to properly identify the claim that the records should be attached to.

  In this instance, we have already received the claim (hopefully, electronically), therefore, we DO NOT need a copy of the claim.

  If using the fax # 602-253-5472, send 1 fax per CRN (cover sheet attached). We have been receiving faxes containing multiple CRNs (cover sheets and records). AHCCCS then must sort through this one large fax attempting to properly separate the records and CRNs. This is very time consuming and has created some sorting errors as well.

If you choose to send the claim hard copy (initial submission) with Medical Records attached – be advised that the processing time will be longer than if the claim was submitted electronically and the records sent after the fact to be attached. There is also the possibility of keying errors. In this instance, submitting the claim (initial submission, hard copy, with records attached) there is no need to utilize the Medical Record cover sheet attached.

Please NOTE…..the Medical Records cover sheet is not intended for use when submitting initial claims – only for use when AHCCCS has received and assigned a valid CRN.

Any questions regarding these processes – please contact kyra.westlake@azahcccs.gov.

END OF STATE FUNDS TO PAY MEDICARE PART D PRESCRIPTION DRUG CO-PAYMENTS

A notice was sent by AHCCCS regarding End of State Funds to Pay Medicare Part D Prescription Drug Co-payments. This notice has been sent to dual eligible members and the contracted AHCCCS Health Plans. This discontinued coverage of the copays will not affect our AHCCCS American Indian Health Program (AAIHP) members and should not significantly impacts I/T/Us. Benefit coordinators for our AAIHP members may find this information helpful as they play a significant role in assisting patients, especially elders, in reading their benefits correspondence. This notice is up on our AHCCCS website (www.azahcccs.gov) for your reference.

TO: AHCCCS Claims
P O Box 1700
Phoenix, AZ 85002

Medical Documentation

CRN(required):_____

DOS:_____

Comments:

_____

_____

_____

From: _____
Phone or Fax # (required)_____
Date:_____

CLAIM CORRECTION REQUEST FORM

Please complete one request form for each Provider ID. All fields are required to be filled.

Provider Name: ____________________ **AHCCCS Provider ID #:** ______________ **Provider Representative:** ____________________

Provider Fax #: ________________________ **Provider Phone #:** ________________________

Recipient's name:		Recipient's AHCCCS ID:	Dates of service:	Billed amount:
CRN:	Fields to be Changed / Comments / Questions:			
Recipient's name		Recipient's AHCCCS ID:	Dates of service:	Billed amount:
CRN:	Fields to be Changed / Comments / Questions:			
Recipient's name		Recipient's AHCCCS ID:	Dates of service:	Billed amount:
CRN:	Fields to be Changed / Comments / Questions:			
Recipient's name		Recipient's AHCCCS ID:	Dates of service:	Billed amount:
CRN:	Fields to be Changed / Comments / Questions:			
Recipient's name		Recipient's AHCCCS ID:	Dates of service:	Billed amount:
CRN:	Fields to be Changed / Comments / Questions:			

This is to certify the information submitted and changes listed/requested on this Claim Correction Request Form are true, accurate and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.		Date
Signature of Provider Representative (Required):		

Please fax form to 602-253-5472 Attention: Claims Research.
If you have any questions please contact Claims Customer Service at 602-417-7670 Option #4.